Date DHS 911 Received:

Child Care Connection Hawaii

A Child Care Services Program of the State of Hawaii, Department of Human Services

APPLICATION FOR CHILD CARE SERVICES

ELIGIBILITY REQUIREMENTS (MUST MEET BOTH)	DOCUMENTATION REQUIRED
1. Child must be under age 13 or between 13 and 18 if unable to care for self or under court supervision.	Children's birth certificates, baptismal or hospital certificates, or court decree.
2. Child for whom assistance is being requested must reside with the applicant. The applicant must be a parent, legal guardian or representative authorized by the child's parents.	Birth document or other court decree. Social Security number for all household members listed on application. (45 CFR 205.52(a)(1))

REASON FOR CHILD CARE (CHECK ALL THAT APPLY)	DOCUMENTATION REQUIRED
☐ Parents in Education, Training or Employment	School enrollment documents which show credits/ hours enrolled, pay stubs for the past 2 months, or if self-employed, current copy of G45 tax form and General Excise tax license.
☐ Special Needs children	Signed statement from health professional/agency representative.
☐ Receiving Child Protective Services	Social worker's evaluation and referral.
☐ I may lose my job because of child care problems.	Written warning from employer.
☐ I have been offered a job and will start on _____	Written proof of job offer.

STATEMENT OF APPLICANT

I hereby certify that all the information contained on this form is true and correct to the best of my knowledge. I submit this application with the understanding that I will give any additional information which may be needed and will allow the Department to verify my statements either with me or through other sources as necessary.

I fully understand and accept my responsibility to report changes in my situation including changes in my child care, school/training schedule, income or residence within 10 calendar days. Furthermore, I understand that if I fail to report changes and receive services to which I am not entitled, the amount of overpayment will be collected from me, and I may be prosecuted for fraud.

ELECTRONIC BENEFITS TRANSFER (EBT): I am responsible to report lost, stolen, or misused EBT cards immediately by calling the EBT toll-free customer service telephone number. I understand that there will be no replacement of any benefits accessed with an EBT card prior to the card being reported lost, stolen or misused. I am responsible to report immediately any changes in the status of my alternate payee. I understand there will be no replacement of any benefits accessed by alternate payees or any other individuals using an EBT card and a valid PIN. I understand that for DHS "cash assistance household" accounts, EBT benefits not withdrawn for ninety (90) days will be returned to the State. I understand that benefits that are returned to the State may be used to offset any outstanding debts that are still owed by my household. (HAR 17-681-51 and 17-681-56)

I understand that I have a right to request a case record review and administrative appeal if I do not agree with the Department's decision on my application for services.

Applicant Signature: _____Date: _____

Co-applicant Signature: _____Date: _____

FILL OUT THE FORM COMPLETELY AND RETURN IT WITH REQUIRED DOCUMENTS TO:

PLEASE PRINT Write down your current residence and mailing address, and then list all family members now living in your home.

RESIDENCE ADDRESS:	MAILING ADDRESS	HOME PHONE:
		FATHER WORK:
		MOTHER WORK:

F.M.	NAME: First M.I. Last	Soc. Security No.	Birth Date (mo/day/yr)	Sex (M or F)	Race	Education (last complete grade)	Marital Status	Employ/Sch.	Employer or School Address/Phone	Start Time	End Time
01	Father										
02	Mother										
11	Child					Child Care requested?		YES NO	Special Needs? YES NO		
12	Child					Child Care requested?		YES NO	Special Needs? YES NO		
13	Child					Child Care requested?		YES NO	Special Needs? YES NO		
14	Child					Child Care requested?		YES NO	Special Needs? YES NO		
15	Child					Child Care requested?		YES NO	Special Needs? YES NO		

Public Assistance and Child Protective Services Eligibility	
Check (√) all boxes that apply if your family is now receiving public assistance	
AFDC or General Assistance	
Food Stamps	
Hawaii Quest	
SSI	
Active Child Protective Services	
Medicaid	
Rent Subsidy	

Type of Monthly Income	Amount	Source of Verification (For Department Use Only)
Employment Earnings (including Self-Employed)	$	
Interest/Dividends	$	
Unemployment Insurance	$	
Worker's Compensation / TDI	$	
Income From Rental Unit	$	
Alimony	$	
Child Support	$	
Military Allotment	$	
Pensions/Other Income	$	
TOTAL INCOME	$	

ELIGIBILITY DISPOSITION (For Department Use Only)

☐ APPROVED

- ☐ Referred by CWS Worker
- ☐ Currently receiving AFDC
- ☐ Currently receiving SSI Benefits
- ☐ Currently receiving Food Stamps
- ☐ Currently receiving Medicaid / Hawaii Quest
- ☐ Currently receiving Rent Subsidy
- ☐ Not on public assistance BUT Income Eligible

Family size _____

85% SMI $_____

Total Income $_____

☐ Fund Code: AT-RISK CCDF ICPS TCC

☐ DENIED

- ☐ Family income: $_____ more than DHS Income Limit
- ☐ Other reasons :_____

_____

_____

☐ APPLICATION WITHDRAWN _____ Date

_____ DHS STAFF _____ Date